

CERTIFICATE OF DEATH

13023

13023

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13966

CERTIFICATE OF DEATH

Reg. Dist. No. 13943

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN lb Ellicott City			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 133 S. St. Johns Lane				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last SALLIE ROGERS BAER				4. DATE OF DEATH Month Day Year Dec. 21, 1960 19			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 26, 1877	
9. AGE (In years last birthday) yrs. 83		10. IF UNDER 1 YEAR Months Days Hours Min. 106 years		11. BIRTHPLACE (State or foreign country) Ellicott City, Md		12. CITIZEN OF WHAT COUNTRY?	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home				10b. KIND OF BUSINESS OR INDUSTRY None			
13. FATHER'S NAME John G. Rogers				14. MOTHER'S MAIDEN NAME Rebecca Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Miss Leila Rogers, 133 S. St. Johns Lane, E.C. Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 422.1 DUE TO (b) Arteriosclerotic cardio-vascular disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) 106 years PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 3-16 , 19 57 , to 12-21 , 19 60 that I last saw the deceased alive on 12-20 , 19 60 , and that death occurred at 8:30 A. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 446 Church Rd Ellicott City, Md DATE SIGNED 12-22-60 ACTUAL SIGNATURE Thomas F. Herbert, M.D. PHYSICIAN'S NAME (Type) Thomas F. Herbert, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-23-60			
22c. NAME OF CEMETERY OR CREMATORY Mt. Olivet				22d. LOCATION (City, town, or county) (State) Frederick, Md			
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE DEC 27 '60			
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1920

NAME OF DECEASED John J. ...
 SEX Male AGE ...
 PLACE OF BIRTH ...
 DATE OF DEATH ...

CAUSE OF DEATH ...
 PLACE OF DEATH ...
 SIGNATURE OF PHYSICIAN ...

SIGNATURE OF REGISTRAR ...
 OFFICE OF THE REGISTRAR

DATE OF REGISTRATION ...
 OFFICE OF THE REGISTRAR

REMARKS ...

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

13367 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13367 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Howard b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City c. LENGTH OF STAY IN 1b MARYLAND d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 57 Main St.				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City d. STREET ADDRESS 57 Main St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) JAMES OLIVER BOLDISON				4. DATE OF DEATH Month Dec. Day 7 Year 1960			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12-10-1880	
9. AGE (In years last birthday) 79 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Oella, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lemuel Boldison				14. MOTHER'S MAIDEN NAME Hatfield			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-05-1118		17. INFORMANT Mrs. Annie Boldison, 57 Main St. Ellicott City Md Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Cardio Vascular Disease (c) 420-1 DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 15 min. 5 years	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE: George E. Burgtorf M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) George E. Burgtorf M D				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				Address (Street, city, town, or county) Dec. 9, 1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-10-60		22c. NAME OF CEMETERY OR CREMATORY St. Johns		22d. LOCATION (City, town, or country) (State) Ellicott City, Md	
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DEC 12 '60		24b. REGISTRAR'S SIGNATURE Carlton S. Hume	

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1900 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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1. PLACE OF DEATH a. COUNTY <u>Hawaii</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u>		b. COUNTY <u>Hawaii</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seagoville</u>		c. LENGTH OF STAY IN 1b <u>76 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Seagoville</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Stansfield Road</u>				e. STREET ADDRESS <u>Stansfield Road</u>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Benjamin Franklin Coan</u>				4. DATE OF DEATH Month <u>Dec</u> Day <u>15</u> Year <u>1960</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 7 1884</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		11. IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Coan</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Disney</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Ther. Lois Sander Laurel, Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Auto suspended respiration</u> DUE TO <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month <u> </u> Day <u> </u> Year <u> </u> Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>1958</u> to <u>Dec 15, 1960</u> , that (I) (we) last saw the deceased alive on <u>Dec. 15, 1960</u> and that death occurred at <u>10:50 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Robert C. Wingfield</u> M.D.				22b. DATE SIGNED <u>December 17, 1960</u>		22c. PHYSICIAN'S NAME (Type) <u>ROBERT C. WINGFIELD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/18/60</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Emmanuel Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Seagoville, Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>De Witt Sander Laurel, Md</u>				25a. REC'D BY REGISTRAR <u> </u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

CERTIFICATE OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13971

13946

1. PLACE OF DEATH a. COUNTY <u>Haward</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Haward</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Savage</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Savage</u>			
c. LENGTH OF STAY IN 1b <u>8 mos.</u>				d. STREET ADDRESS <u>615 Washington St</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>315 Washington St</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Grace M. Davis</u>				4. DATE OF DEATH <u>December 22 1960</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec 7 1882</u>	9. AGE (In years last birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Savage Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Ralph Lee</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth Cole</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>Mrs Beatha Canaway, Savage Md</u> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardio-Vas. Disease</u> DUE TO (c) <u>Epilepsy</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>3 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Dec 1st 58</u> to <u>Dec 22 60</u> , that (I) (we) last saw the deceased alive on <u>Dec 22 1960</u> , and that death occurred at <u>3 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank E. Shipley</u>				22b. ADDRESS <u>Savage, Md.</u>			
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>12/24/60</u>		<u>Savage Cemetery</u>		<u>Savage Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Witt Canadian Laurel, Md</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 30 '60</u>		25b. REGISTRAR'S SIGNATURE <u>Robert S. Kram</u>	

13071

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13973 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12-13-60 at 13947

1. PLACE OF DEATH a. COUNTY Howard		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b MARYLAND		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Howard		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		d. STREET ADDRESS RFD 2		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY ELIZABETH DAVIS		4. DATE OF DEATH Month Day Year Dec. 6, 1960		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated <input checked="" type="checkbox"/>		8. DATE OF BIRTH June 4, 1883 1888		9. AGE (In years last birthday) 77 1/2 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Howard County Md		12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME George Wolfe		14. MOTHER'S MAIDEN NAME Mrs. Mary Hoffman		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. None			
17. INFORMANT Mrs. E.B. Saunders, RFD 2, Ellicott City, Md		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) Arteriosclerosis DUE TO cause last.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE George E. Burgtorf		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12-6-1960		EXAMINER'S NAME (Type) George E. Burgtorf M D		Address (Street, city, town, or county)		12-6-1960			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-9-1960		22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or country) (State) Baltimore, Md		23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DEC 8 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

MEDICAL CERTIFICATION

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CERTIFICATE OF DEATH

Reg. Dist. No. 13948

13968

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Shaffers Convalescent Retreat		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First SADIE Middle HALBERT Last		4. DATE OF DEATH Month Dec. Day 12 Year 1960	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 8, 1886
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Baltimore, Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. None	
17. INFORMANT Martin Shaffer, Montgomery Road, Ellicott City, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 443X DUE TO CVA Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) HTASCVD (c) INTERVAL BETWEEN ONSET AND DEATH 2 days 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 1958 to 12-12 , 19 60 that I last saw the deceased alive on 12-11 , 19 60 , and that death occurred at 1:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 409 Columbia Rd Baltimore, Md DATE SIGNED 12-14 1960 ACTUAL SIGNATURE PV Thorpe M.D. PHYSICIAN'S NAME (Type) PETER V. THORPE, MD ELlicott City, Md			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12-15-60	22c. NAME OF CEMETERY OR CREMATORY Parkwood	22d. LOCATION (City, town, or county) (State) Baltimore, Md
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md		24a. REC'D BY REGISTRAR DATE DEC 19 '60	24b. REGISTRAR'S SIGNATURE Calvin S. Kenna

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 9/58

CERTIFICATE OF DEATH

Board of Health

City of Albany

County of Albany

Date of Death

Age at Death

Sex

Color

Residence

Occupation

Cause of Death

Signature of Physician

Signature of Registrar

Signature of Medical Officer

Signature of Health Officer

Signature of Coroner

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any death is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13976 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13949

1. PLACE OF DEATH a. COUNTY Howard MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Howard		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Simpsonville		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			d. STREET ADDRESS		
3. NAME OF DECEASED (Type or print) First MARY Middle CHRISTINE Last HUNT			4. DATE OF DEATH Month December Day 4 Year 19 60		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 26, 1908	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months 4 Days 19 Hours 60 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) Pitchburg, Mass		12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME James Deery			14. MOTHER'S MAIDEN NAME Mary Deery		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. -	17. INFORMANT John W. Hunt, Box 498, Randallstown, Md		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of head DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) 976x					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
22a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) Shot self through mouth			
22c. TIME OF INJURY Month, Day, Year Dec 12/4/ 19 60	22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) House	22f. (City or town) Simpsonville, Howard, Maryland	(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE Russell S. Fisher		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 12/5/60	
EXAMINER'S NAME (Type) Russell S. Fisher, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 8, 1960	22c. NAME OF CEMETERY OR CREMATORY National Cemetery	22d. LOCATION (City, town, or country) (State) Arlington, Va.	
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md			24a. REC'D BY REGISTRAR DEC 8 '60		
			24b. REGISTRAR'S SIGNATURE Arthur S. Hume		

MEDICAL CERTIFICATION

MASSACHUSETTS DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
BUREAU OF VITAL RECORDS
100 NORTHERN AVENUE, BOSTON, MASSACHUSETTS 02111

THE STATE
OF MASSACHUSETTS

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any changes are necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY Howard						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Ellicott City						b. COUNTY Howard					
c. LENGTH OF STAY IN b Tridelphia Road						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Tridelphia Road						d. STREET ADDRESS Tridelphia Road					
3. NAME OF DECEASED (Type or print) ANNIE JOHNSON						4. DATE OF DEATH Dec. 22, 1960					
5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 28, 1899		9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY?		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME William Johnson						14. MOTHER'S MAIDEN NAME Fannie Rogers					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No						16. SOCIAL SECURITY NO. 219-38-7845					
17. INFORMANT Henry Johnson, Bethany Lane, Ellicott City, Md						17. INFORMANT Henry Johnson, Bethany Lane, Ellicott City, Md					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardio-Vascular Disease</i>											
422.1 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO											
(c) DUE TO											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
DATE SIGNED 12-23-60											
ACTUAL SIGNATURE <i>George E. Burgtorf</i> M.D.											
EXAMINER'S NAME (Type) George E. Burgtorf											
Address (Street, city, town, or county)											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
22b. DATE THEREOF 12-26-60											
22c. NAME OF CEMETERY OR CREMATORY Browns Chapel											
22d. LOCATION (City, town, or country) (State) Dayton, Md											
23. FUNERAL DIRECTOR F.C. Higinbotham, Ellicott City, Md											
24a. REC'D BY REGISTRAR DEC 29 '60											
24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kraus</i>											

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MEDICAL EXAMINER CERTIFICATE OF DEATH

STATE OF MARYLAND

CERTIFICATE OF DEATH

IN THE CITY AND COUNTY OF BALTIMORE

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

DATE OF BIRTH

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF MARRIAGE

DATE OF DEATH

DATE OF BURIAL

DATE OF INTERMENT

DATE OF CREMATION

Reg. Dist. No. 13951

1. PLACE OF DEATH a. COUNTY HOWARD		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FULTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X SAME AS #1	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RT 216		e. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) EDWARD		4. DATE OF DEATH Month DEC Day 15 Year 1960	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 19 JAN 1938
9. AGE (In years last birthday) 22 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MACHINIST HELPER		10b. KIND OF BUSINESS OR INDUSTRY PLASTIC INDUSTRY	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME EDWARD AUSTIN MADISON SR		14. MOTHER'S MAIDEN NAME CLAIRE ESTELLE BRADY	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or date of service) YES 1956-59		16. SOCIAL SECURITY NO. 218-34-595	
17. INFORMANT FATHER EDWARD AUSTIN MADISON SR		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GENERALIZED LYMPHOSARCOMATOSIS 202.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LYMPHOSARCOMA LEFT LEG DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NONE EXCEPT HISTORY OF TRAUMA AT WORK			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 12 MOS 18 MOS.	
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) WAS LIFTING COIL OF WIRE AT NATIONAL PLASTIC CO. ODENTON MD AND BUMPED LEG WHEN HE FELL AGAINST BASK		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. AUG 1959 p. m.		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) ODENTON ANN ARUNDEL MD		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JANUARY, 1960 , to PRESENT, 1960 , that I lost saw the deceased alive on DEC 15, 1960 , and that death occurred at 6:45 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) 402 MAIN ST LAUREL MD DATE SIGNED 12/15/60 ACTUAL SIGNATURE John R. Buell M.D. PHYSICIAN'S NAME (Type) JOHN R. BUELL			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/17/60	
22c. NAME OF CEMETERY OR CREMATORY St Pauls Lutheran		22d. LOCATION (City, town, or county) (State) Fulton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE W. W. Samsel		24a. REC'D BY REGISTRAR DATE DEC 21 '60	
ADDRESS Laurel Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13978

CERTIFICATE OF DEATH

Reg. Dist. No.

13952

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elchester		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Old Elchester Road		d. STREET ADDRESS Old Elchester Road	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Donald Middle John Last McDonald		4. DATE OF DEATH Month Dec. Day 25 Year 19 60	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Date 3/6/1892
9. AGE (In years last birthday) 68 yrs.		10. IF UNDER 1 YEAR Months 68 Days 68 Hours 68 Min.	11. IF UNDER 24 HRS. Months 68 Days 68 Hours 68 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Electrification		10b. KIND OF BUSINESS OR INDUSTRY Self employed	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Edward B. McDonald		14. MOTHER'S MAIDEN NAME Mary Anna Koeder	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212-18-2042	
17. INFORMANT Mrs. Cecilia McDonald Elchester, Md.		Address Mrs. Cecilia McDonald Elchester, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Grade IV Cardiac Decongestion 420.1 DUE TO Pulmonary edema + peripheral Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) circulatory collapse DUE TO Arteriosclerotic Cardio Vasc. Disease (c) Coronary Artery Sclerosis + Benign Hypertension		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Coronary Artery Sclerosis + Benign Hypertension		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN - 1957 , to Dec. 25, 1960 , that I last saw the deceased alive on Dec. 25, 1960 , and that death occurred at 8:00 P. M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Harry L. Knipp M.D.		ADDRESS (Street, city or town, state) 4116 Edmondson Ave. Baltimore 29, Md.	
DATE SIGNED 12/27/60			
PHYSICIAN'S NAME (Type) HARRY L. KNIPP, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/29/1960	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton Funeral Home		ADDRESS Catonsville, Md.	
24a. REC'D BY REGISTRAR SAN 4 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Knapp	

CERTIFICATE OF DEATH

1897

1405

April 12, 1897

WILLIAM BROWN

WILLIAM BROWN

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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CERTIFICATE OF DEATH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

DEPARTMENT OF HEALTH

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel (rural)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Laurel (rural)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Annie Katherine Mosley		4. DATE OF DEATH Dec. 6, 1960	
First Middle Last		Month Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan 10, 1891
9. AGE (In years last birthday) 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Nurse		10b. KIND OF BUSINESS OR INDUSTRY Private home	
11. BIRTHPLACE (State or foreign country) Birmingham, Ala.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME Riley McGraw		14. MOTHER'S MAIDEN NAME Molly Byrum	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Mrs. Grace M. Denslow		Address Forestville, Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Sclerosis DUE TO (c) Genic. arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/11 19 59 to 12/5 19 60 that (I) (we) last saw the deceased alive on 12/1 19 60 and that death occurred at 7:30 AM, from the causes and on the date stated above.			
22a. SIGNATURE J. M. Warren		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) J. M. WARREN		22d. ADDRESS	
23a. BURIAL, CREMATION, REINTERMENT (Specify) Burial		23b. DATE THEREOF Dec. 9, 1960	
23c. NAME OF CEMETERY OR CREMATORY Congressional		23d. LOCATION (City, town, or county) (State) 1801 E St. S.S. Wash. D. C.	
24. FUNERAL DIRECTOR'S SIGNATURE Robert Donaldson		25a. REC'D BY REGISTRAR DEC 14 '60	
ADDRESS James M. D.		25b. REGISTRAR'S SIGNATURE Arthur S. Kress	

CERTIFICATE OF DEATH

13972

(Signature)

(Signature)

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CERTIFICATE OF DEATH

Reg. Dist. No. 13954

13980

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Glenelg				c. LENGTH OF STAY IN 1b X Glenelg			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First MARY Middle AURELIA Last MULLINIX				4. DATE OF DEATH Month Dec. Day 21 Year 1960			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 8, 1876	
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) At Home		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Frederick Co. Md		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME David Specht				14. MOTHER'S MAIDEN NAME Mary Kessler			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Joseph A. Mullinix, Glenelg, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary failure, arteriosclerosis DUE TO 43000 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Heart disease, Arterio bronchitis. DUE TO (c) Arteriosclerosis generalized. Similarity		INTERVAL BETWEEN ONSET AND DEATH 1957 to 21 Dec 60					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1957 , 19____, to 21 Dec, 1960 , that I last saw the deceased alive on 21 Dec , 19____, and that death occurred at 2:00 P. M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Howard E. Hall M.D.				ADDRESS (Street, city or town, state) Sylmar, Ark DATE SIGNED 21 Dec 60			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-24-60		22c. NAME OF CEMETERY OR CREMATORY Mt. View		22d. LOCATION (City, town, or county) (State) Alpha, Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.C. Higinbotham, Ellicott City, Md				24a. REC'D BY REGISTRAR DATE DEC 27 '60		24b. REGISTRAR'S SIGNATURE Arthur L. Hines	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

13970

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13955

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore City			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City				c. LENGTH OF STAY IN 1b 4½ mos.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 7 3V01-4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Taylor Manor Hospital				d. STREET ADDRESS 5310 Gwynn Oak Avenue			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First James Middle David Last Norris				4. DATE OF DEATH Month December Day 23 Year 19 60			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct 2, 1892	
9. AGE (In years last birthday) 68 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bricklayer		10b. KIND OF BUSINESS OR INDUSTRY Construction		11. BIRTHPLACE (State or foreign country) Virginia	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Samuel Norris		14. MOTHER'S MAIDEN NAME Rachael Hurley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 218-09-3049		17. INFORMANT Mrs. Mary E. Norris - 5310 Gwynn Oak Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 422 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause lost. (b) DUE TO Arteriosclerotic cardio vascular disease (c)						INTERVAL BETWEEN ONSET AND DEATH 3 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary emphysema						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from August 4, 1960 to December 23, 1960 that (I) (we) last saw the deceased alive on December 23, 1960 and that death occurred at 12:45 pm from the causes and on the date stated above.							
22a. SIGNATURE Stephen Lee Magness				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED Dec 23, 1960	
22c. PHYSICIAN'S NAME (Type) Stephen Lee Magness, M.D.				22d. ADDRESS Taylor Manor Hospital, Ellicott City, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/27/1960		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION (City, town, or county) (State) Woodlawn Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Ellsworth Armacost				ADDRESS Liberty Hghts. Ave.		25a. REC'D BY REGISTRAR DATE DEC 27 '60	
				25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

CERTIFICATE OF DEATH

13910

Blank certificate form with faint lines and text.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be re-issued by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13972

CERTIFICATE OF DEATH

Reg. Dist. No. 13956

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAVAGE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SAVAGE</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>1 Baltimore Ave</u>	
3. NAME OF DECEASED (Type or print) <u>CHARLES HERBERT RILEY</u>		4. DATE OF DEATH <u>Dec 11 1960</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 22 1877</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Mill Worker</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SAVAGE MFG CO</u>	
11. BIRTHPLACE (State or foreign country) <u>Lowdon County, Va</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>ANNIE RILEY</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Goldie Leishure</u>		Address <u>31 Brandon St Laurel</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ac. Cardiac Congestive Failure</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Ch. Hypertensive Cardio-Vascular Disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>3 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Dec 11 1960</u> to <u>Dec 11 1960</u> , that I last saw the deceased alive on <u>Dec 11 1960</u> , and that death occurred at <u>3 a</u> M, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <u>Savage, Md.</u> DATE SIGNED <u>12/12/60</u>	
ACTUAL SIGNATURE <u>Frank E. Shipley</u> M.D.		PHYSICIAN'S NAME (Type) <u>Frank E. Shipley</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec 14/60</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>My Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Laurel P. Co Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ridgley Selby</u> ADDRESS <u>5002 4th St Laurel Md</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 20 '60</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kears</u>			

[The page contains faint, illegible text.]

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13981 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13957									
1. PLACE OF DEATH a. COUNTY Howard					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Montgomery c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Woodbine Rt 2 d. STREET ADDRESS 158-2				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hipsley Mill Road c. LENGTH OF STAY IN 1b Woodbine d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First Middle Last DAVID E WILSON					4. DATE OF DEATH Month Day Year Dec. 7, 1960 19				
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 22, 1944		9. AGE (In years last birthday) 16 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Work				10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James M. Wilson					14. MOTHER'S MAIDEN NAME Ruth Howard				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT James M. Wilson			Address Same as 2		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of perineum 919.8 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 10 Min.	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.) While hunting climbed on stump, pulled gun up and accidentally discharged.					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 6:45 PM 12-7-60 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Woods		20f. (City or town) (County) (State) Woodbine (rural) Howard Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> end in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>George E. Burgtorf</i>					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) George E. Burgtorf M.D.					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
					DATE SIGNED 12-7-60				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-10-60		22c. NAME OF CEMETERY OR CREMATORY Laytonsville		22d. LOCATION (City, town, or county) (State) Laytonsville, Md.			
23. FUNERAL DIRECTOR <i>Francis H. Barber</i> Laytonsville, Md.						24a. REC'D BY REGISTRAR DEC 9 '60		24b. REGISTRAR'S SIGNATURE <i>Charles L. Kraus</i>	

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